

Terry and Colleagues Respond

In response to Bright and Moore, we have several points we wish to clarify concerning our estimate of the number of US women with cosmetic breast implants.¹

We were disconcerted to read Bright and Moore's claim that we "disparaged" the methods of others. On the contrary, reference to the available estimates^{2,3} was made to point out that we did not rely solely on self-report of breast implants (which would most likely lead to underreporting of implant prevalence). The comparison was intended to explain that different methodologies will produce different estimates, and that all methods have limitations. In addition, their criticisms of our paper appear to be based on a misunderstanding of our methods, results, and discussion.

Bright and Moore maintain that we used potentially "untenable" assumptions. In fact, they incorrectly state our assumptions, which are explicitly outlined in equation 1 of our paper (p 1123). The parameter "Hosp%" (0.53917) assumes that only a proportion of all procedures were performed in hospitals (rather than in private offices or ambulatory centers). The parameter "NY%," used to account for regional variations in prevalence, was 0.05721. The parameter "Base%," used to adjust for annual variations in prevalence, was 0.06511.

Bright and Moore also discuss two points that we addressed in our paper, namely, the impact of subsequent procedures performed at different sites and the miscoding of unilateral procedures. Both of these factors would lead to an overestimate of the prevalence of breast implants, which we acknowledged in our paper.

Figure 1 does not report a 95% confidence interval, as Bright and Moore state. It reports a distribution of estimates generated by 10 000 iterations of our formula, 95% of which were 1 205 820 or below. These iterations were conducted by varying each parameter through the range of its underlying distribution.

Our paper did not attempt to represent an estimate beyond its stated purpose, that is, the number of US women who had cosmetic augmentation mammoplasty in the years 1963 to 1988. Extrapolation of our estimate to later reference years, as Bright and Moore attempt, will be more meaningful when more recent national data become available. It is our belief that using simulation methods as

well as data sources that do not rely solely on self-report provides an estimate of the prevalence of cosmetic breast implants that, albeit potentially overestimated, takes into account some of the uncertainty in the underlying variables. □

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References

1. Terry MB, Skovron ML, Garbers S, Sonnenschein E, Toniolo P. The estimated frequency of cosmetic breast augmentation among US women, 1963 through 1988. *Am J Public Health*. 1995;85:1122-1124.
2. Bright RA, Jeng LL, Moore RM. National survey of self-reported breast implants: 1988 estimates. *J Long Term Effects Med Implants*. 1993;3:81-89.
3. Cook RR, Delongchamp RR, Woodbury M, Perkins LL, Harrison MC. The prevalence of women with breast implants in the United States, 1989. *J Clin Epidemiol*. 1995;48:519-525.

Nonfatal Injuries among US Children

The article "The Epidemiology of Nonfatal Injuries among US Children and Youth" was well written and informative.¹ However, there are a few questions we would like to address concerning the methods used as well as offer a number of comments on the significance of the study of nonfatal injuries among children.

A concern on methodology involves the "trained coders" discretionary classification of injuries using the ICD-9 E-codes. Depending on how thoroughly these coders are trained, it is not difficult to imagine that errors could be made on classification. There was no mention of adjustment for such potential errors that may affect the statistics. Some clarification also is needed in the results. The results were based upon a total of 2773 injuries requiring medical attention. The article should state explicitly that the estimates for nonfatal injuries are based solely upon the *medically* reported injuries, and hence the true rates and mixes

for all nonfatal injuries could be significantly different from those reported in the article.

The conclusions indicate that the findings of the presented research are in line with previous reports that have been made. In this decade where cutting cost is a key factor in our nation's health care system, it seems that, more than ever, researchers must be sensitive to the allocation of the public's tax dollars and be selective in their studies. It appears that in just the last decade, numerous reports have been done regarding children's injuries, all of which suggest that medically attended injuries occur in at least 25% of children annually. Although findings in such reports have been useful in identifying causes and preventing unnecessary injuries, we feel that the results are not surprising; rather, they should be expected in future studies. Children are children, and they will get in trouble. We suggest that, rather than studying such broad trends about the percentage of injuries annually, more research should be done in institutions such as day care centers, which are proliferating because of the obligations of working parents, especially mothers. Perhaps it is justified that more research is done regarding fatal injuries as well. Those related to violence are especially needed. We also suggest that more investigations be done in nonfatal injuries caused by physical abuse, drug abuse, molestation, neglect, etc. While direct causes of injuries are important to know, real prevention can be accomplished only by understanding the mechanisms responsible for the injuries, especially in this decade of high-risk behaviors and associated risks surrounding and among children. □

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Reference

1. Scheidt PC, Harel Y, Trumble AC, et al. The epidemiology of nonfatal injuries among US children and youth. *Am J Public Health*. 1995;85:932-938.

Scheidt and Colleagues Respond

Kim and Graves raise several issues. In response to their concern about E-